UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

CHARLES BRYANT, individually and as next friend and guardian of D.B., *et al*,

Plaintiffs,

v.

NEW YORK STATE EDUCATION DEPARTMENT, *et al*,

Defendants.

AFFIDAVIT OF EDWARD A. SASSAMAN, M.D.

No. 8:10-CV-36 (GLS / RFT)

I, Edward A. Sassaman, M.D., being duly sworn, upon my own personal knowledge, hereby depose and state as follows:

1. I have been a registered Board Certified physician, licensed to practice in Massachusetts since 1976 and licensed to practice in New York since 1994. My office is located at 165 Court Street, Rochester, New York 14647.

2. I am Certified by the American Board of Pediatrics in the area of General Pediatrics. I am also a Fellow of the American Academy of Pediatrics.

3. I have been appointed by the New York Department of Health as an Expert Reviewer in Pediatrics for the Office of Professional Medical Conduct in Albany, New York for approximately five years. I serve as the Regional Medical Director of Excellus BlueCross BlueShield, Rochester Region, in Rochester, New York, where I am responsible for developing and implementing managed care programs for children throughout all of Excellus.

4. I graduated from Harvard Medical School in 1973 and completed my residency and fellowship at Children's Hospital Medical Center in Boston, Massachusetts. My fellowship was in Developmental Disabilities.

5. I have been a consulting physician to the Judge Rotenberg Educational Center, Inc. ("JRC") for over twenty years. In this capacity, I visit the JRC facility and examine all of the students there on a monthly basis. In addition, I speak with the nursing and treatment staff at JRC on a daily basis, oftentimes having multiple conversations with JRC healthcare workers in a single day, to consult on the students' treatment and medical issues. I also conduct a yearly physical and record review for each student at JRC. All of this is done as part of my monitoring of the health of all of the JRC students.

6. As part of my duties, I have been following the health and treatment progress of the following seven (7) students since their admission date to JRC, which is indicated in parentheses next to their initials: D.B. (September 17, 2004), B.G. (September 12, 2008), A.J. (March 8, 2007), D.P. (December 8, 2008), J.R. (October 17, 2008), S.T. (March 13, 2009), and G.T. (February 29, 2008) (collectively referred to as the "Students"). I have seen all of the Students on a monthly basis as described above and have monitored their health while they have been receiving behavior modification at JRC.

7. I am familiar with the behavior modification treatment given by JRC to its students including the operation and effect of the GED and GED-4 skin shock devices. One of my duties at JRC is to examine the JRC students before they receive skin shock treatment with the GED and GED-4 devices and determine whether there are any medical contraindications to using the GED and GED-4 devices with that particular student. I have examined hundreds of students, dating back to 1990, who were receiving applications of the GED and GED-4 devices.

8. Since their admission to JRC, I have personally examined each of the Students. In addition, in July and August of 2009, each of the Students received another physical examination conducted by either myself or Dr. Maria Kane, at my direction, at the JRC facility. I personally reviewed all of the medical examination reports for each of the Students from the day they were admitted to JRC through and including the date of the examination. Following the examination and my review of each student's medical records, I wrote a report for each individual student. Signed, appropriately redacted copies of the reports for each student report are attached hereto as Exhibits A – G, collectively. The Students suffer severe behavior disorders that have caused them to inflict severe physical harm on themselves as well as others.

9. The reports I wrote following each student's examination and my review of their medical records in July and August 2009 and my opinions are summarized below:

A. ***D.B.*** ***(DOB: 10/25/1994)***

i. D.B. is a 15 year old male suffering from Pervasive Developmental Disorder, Mild Mental Retardation and Intermittent Explosive Disorder. He has a long history of spitting, biting, hitting and self-injurious behavior. He has been on various psychotropic medications in the past including Zoloft, Tenex, Seroquel, Ativan, and Droperidol, none of which were effective in controlling his behavior. He has been placed at numerous special education and mental health schools and facilities in the past. During the past year at JRC, D.B. has been restrained many times. He is currently on no medications, because past medications had no therapeutic effect on his behavior. Removal of psychotropic medication from his treatment reduces his risk of suffering further negative side effects of such medications, however, he still requires treatment with behavior therapy.

ii. If D.B. is not allowed to participate in the aversive program at JRC, it is my opinion that his severe behaviors will not be brought under control. He will frequently need to be restrained and could hurt himself or others as a result of his severe behaviors. He will miss large amounts of classroom time. There are no contraindications whatsoever to using aversive therapy with D.B. and I believe it is the most effective program for him.

B. ***A.J.*** ***(DOB: 07/17/1994)***

i. A.J. is a 15 year old woman with Autism and Mental Retardation. A.J. has a long history of severe self-injurious behavior including picking at her gums, slicing her tongue with her finger nails, defecating and smearing feces, spitting, biting, assaultive behavior, and severe self-injurious behavior. She has been on numerous psychotropic medication in the past including Zyprexa, Seroquel, Klonopin, Topamax, Thorazine, and Risperdal, none of which were effective in controlling her behavior. She has also been placed at numerous special education and mental health schools and facilities in the past. A.J. is currently on no medications, because past medications had no therapeutic effect on her behavior. Removal of psychotropic medication from her treatment reduces her risk of suffering further negative side effects of such medications, however, she still requires treatment with behavior therapy.

ii. It is clear from A.J.'s records and her current stay at JRC that medications and previous treatment programs have not worked for A.J. If A.J. were deprived of aversive treatment, she would run a severe risk of sustaining a significant injury (or injuring others) during her self-injurious and acting-out behaviors. There are no contraindications to using aversive therapy with A.J. and I believe it is the most effective way to control her behavior.

C. ***B.G.*** ***(DOB: 6/12/1996)***

i. B.G. is a 13 year old man with Autism and Mental Retardation. He has a long history of severe self-injurious and acting out behavior including kicking, hitting, head banging, and head butting. B.G. has been placed at numerous special education and mental health schools and facilities in the past. He has been on numerous psychotropic medications in the past including Risperdal, Seroquel, Cogentin, and Clonidine, none of which were effective in controlling B.G.'s behavior. He is currently on no medications, because past medications had no therapeutic effect on his behavior. Removal of psychotropic medication from his treatment reduces his risk of suffering further negative side effects of such medications, however, he still requires treatment with behavior therapy.

ii. It is obvious from reviewing B.G.'s past history and records that previous treatment programs and medication trials have not been effective in controlling B.G.'s self-injurious and acting out behaviors. If B.G. were to be denied access to an effective behavior management program including aversives, he would run a significant risk of injuring himself or others. There are no contraindications to using aversive therapy as part of a treatment program for B.G. and I believe it is the most effective way to control his behavior.

D. ***D.P.*** ***(DOB: 1/9/1991)***

i. D.P. is an 18 year old man with a Bipolar Disorder, a Mood Disorder, and borderline intelligence. He has a long history of severe behavior problems including assaulting his family and treatment staff, choking staff and destroying property. He has been placed at numerous special education and mental health schools and facilities prior to arriving at JRC. None of those placements were successful in controlling his behavior. Additionally, he has been on psychotropic medications in the past including Depakote and Seroquel. These, too, have not

successfully controlled his behavior. He is currently on no medications, because past medications had no therapeutic effect on his behavior. Removal of psychotropic medication from his treatment reduces his risk of suffering further negative side effects of such medications, however, he still requires treatment with behavior therapy.

ii. Upon reviewing D.P.'s records it is clear that neither previous behavior treatment programs nor psychotropic medications have successfully controlled his severe behaviors. If D.P. were to be deprived of aversive treatment, he would run a severe risk of serious injury or injuring others as a result of his acting out behaviors. There are no contraindications to using aversive therapy with D.P. and I believe it is the most effective way to control his behavior.

E. ***J.R.*** ***(DOB: 5/26/1997)***

i. During the past year, J.R. has been restrained several times as a result of acting out and exhibiting self-injurious behavior. He has been on numerous medications in the past including Depakote, Lithium, and Seroquel to control behavior, without significant beneficial effect. He is currently on Depakote to address his behavior. Other past medications had no therapeutic effect on his behavior. Removal of those medications from his treatment reduces his risk of suffering further negative side effects of such medications, however, he still requires treatment with behavior therapy.

ii. If J.R. is not allowed to participate in the aversive program at JRC, it is my opinion that his severe behaviors will not improve. This does place him at risk for having some major injury in the future related to his behavior. There are absolutely no contraindications to using aversive therapy with J.R. and I think it would be the most successful way to bring his behavior under control.

F. ***S.T.*** ***(DOB: 1/2/1993)***

i. S.T. is a 15 year old man with Mental Retardation and Autism. He has a long history of medication use in the past. He has been previously prescribed Zyprexa, Risperdal, Thorazine, Ativan, and Ambien, none of which have been successful in controlling his behavior. Upon his admission to JRC he was on Zyprexa. Since his admission to JRC, S.T. has pulled out one of his own teeth, a behavior that he has exhibited in the past. He has also exhibited a significant amount of self-injurious behavior related to scratching his skin and picking at his nails, to the point of drawing blood. Similarly, S.T. scratches and picks at his toes. S.T. has had at least two documented paronychias associated with self injurious behavior. His physical examination was benign except for scratch marks on his arms and signs of picking around his fingers due to self abuse.

ii. S.T. has been on numerous medications in the past to control his behavior, none of which have had any significant effect on his behavior. His behavior at the JRC continues to be problematic. He has engaged in self injurious behavior since his admission to JRC. He is being treated aggressively with skin preparations. There is no question that he is an excellent candidate for the GED and there are no contraindications to its use.

G. ***G.T.*** ***(DOB: 1/29/1994)***

i. G.T. is a 15 year old man with Mental Retardation and Autism. He has a long history of severe self-injurious behavior prior to coming to the JRC. He has been on numerous psychotropic medications in the past including Klonopin, Clonidine, and Abilify, none of which had any significant effect in controlling his behavior. Since his admission to JRC, G.T. has had numerous episodes of severe self injurious behavior with head banging. He has a significant hematoma on the back of his head from which blood appears to have been reabsorbed, and he is

left with redundant skin and underlying scar tissue. He has had episodes of bleeding and infections from picking at his nails. He has also picked at the side of his face, and on numerous occasions has scratched himself on his face and neck. G.T. slammed his wrist inside of his desk causing the skin to break down and requiring antibiotic dressings. He has bruised his right eyelid during aggression and restraint and has exhibited several other episodes of head banging and self-injurious behavior. His physical examination was benign although he did have numerous scratches from self injurious behavior as well as evidence of hematomas from which blood had been reabsorbed in the area of his right eye.

ii. In evaluating G.T.'s records, it is obvious that medication has not worked for him, nor have previous behavior treatment programs. If left untreated, G.T. stands a significant risk of severely injuring himself during his head butting, and certainly of injuring other students. There are no contraindications to using aversive therapy to treat G.T. and I think it would be the most successful way to bring his extreme behavior under control.

10. Based on my examinations of the Students and on my review of their medical records, it is my opinion, to a reasonable degree of medical certainty, that none of the Students has any medical contraindication that would preclude the use of the GED or GED-4 devices as part of their treatment, JRC's behavioral treatment program, including the GED and GED-4 devices, is safe and effective and has not injured or caused risk of injury to any student, including the Students.

11. In my opinion, which I hold to a reasonable degree of medical certainty, that JRC's behavioral treatment program, including the use of the GED and GED-4 devices, should be available to the Students. Furthermore, it is my opinion, to a reasonable degree of medical certainty, that the Students will likely suffer severe physical harm if they are denied behavioral

treatment programs, including the use of the GED and/or GED-4, because no other treatment has successfully controlled their dangerous behavior disorders.

12. It is also my opinion, to a reasonable degree of medical certainty, that the health and educational progress of a student who needs aversive therapy but cannot receive it due to the provisions of state regulations banning or curtailing the use of aversive interventions, such as those promulgated by the New York State Education Department, effective June 23, 2006 (collectively, the "NYSED Regulations"), would suffer significantly. It is my further opinion that students, such as these Students, who cannot receive appropriate aversive therapy for their most disruptive, destructive, or non-compliant behaviors have a grave prognosis. Ultimately, the Students will not learn replacement behaviors. Their disruptive, destructive, or non-compliant behaviors will most likely escalate into aggressive and/or health-dangerous behaviors. The resulting behaviors may then cause a Student to be removed to a separate classroom away from his or her classmates which will in turn hinder the Student's social and educational development.

13. It is also my opinion, which I hold to a reasonable degree of medical certainty, that the Students suffer irreparable harm from the enforcement of the NYSED Regulations. As stated above, permanent physical damage to the Students will likely result if treatment with aversive therapy is not available to them. Their aggressive, self-injurious, destructive, disruptive, and non-compliant behaviors will likely continue and the Students will not receive an appropriate education. The Students will likely be prescribed psychotropic medications which would subject them to side-effects such as: severe weight gain, Tardive Dyskinesia, (a disorder involving involuntary or repetitive movements), damage to internal organs, and/or metabolic disorders, including diabetes, which can negatively affect lifespan.

14. Finally, it is my opinion, which I hold to a reasonable degree of medical certainty, that access to aversive therapy is necessary for the health, well-being, and education of the Students. When combined with positive programming and a structured behavioral program, aversive interventions are absolutely critical for these individuals, who present with severe behaviors. With these interventions in place, their self-abusive, aggressive, destructive, major disruptive and non-compliant behaviors will decrease and they will no longer suffer from the physical and emotional damage that has plagued them for most of their lives. Without effective aversive interventions, these Students will most likely continue to exhibit serious behaviors, thereby resulting in no social interaction and no appropriate education.

SWORN TO AND SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 23rd DAY OF DECEMBER, 2009.

s/ Edward A. Sassaman, M.D.
Edward A. Sassaman, M.D.

Sworn to before me this

December 23, 2009

s/ Tracy Johlman
Notary Public

EXHIBIT A

JUDGE ROTENBERG CENTER

A behavioral school for children and adults...

D[redacted] B[redacted]
AUGUST 20, 2009

DOB: [redacted]

D[redacted] is a 14 10/12 year old man with the diagnoses of Pervasive Developmental Disorder, Mild Mental Retardation and Intermittent Explosive Disorder. He has a long history of spitting, biting, hitting and self-injurious behavior. He has been on various psychotropic medications in the past including Zoloft, Tenex, Seroquel, Ativan, and Droperidol, none of which were effective in controlling his behavior. He has been in numerous special education and mental health placements in the past. During the past year at the Judge Rotenberg Center, D[redacted] has been restrained many times preventing him from participating in classroom educational activities. He currently is on no medications.

If D[redacted] is not allowed to participate in the aversive program at the Judge Rotenberg Center, it is my opinion that his severe behaviors will not be brought under control. He will frequently need to be restrained and could hurt himself or others because of his severe behaviors. He will miss large amounts of classroom time. There are no contraindications whatsoever to using aversive therapy with D[redacted] and I believe it is the most effective program for him.

Edward Sassaman M.D.

EXHIBIT B

JUDGE ROTENBERG CENTER

A behavioral school for children and adults....

B[redacted] G[redacted]
AUGUST 20, 2009

DOB: [redacted]

B[redacted] is a 13 2/12 year old man with Autism and Mental Retardation. He has a long history of severe self-injurious and acting out behavior including kicking, hitting, head banging, and head butting. He has been on numerous psychotropic medications in the past including Risperdal, Seroquel, Cogentin, and Clonidine. None of them were effective in controlling B[redacted]'s behavior. He currently is on no psychrotropic medications. B[redacted] has been in numerous special education and mental health placements in the past.

It is obvious from reviewing B[redacted]'s past history and records that previous treatment programs and medication trials have not been effective in contolling B[redacted]'s self-injurious and acting out behaviors. If B[redacted] was denied access to an effective behavior management program including aversives, he runs a significant risk of injuring himself or others. There are no contraindications to using aversives as part of a treatment program for B[redacted]. I believe it is the most effective way to help control his behavior.

Edward Sassaman, M.D.
Edward Sassaman. M.D.

EXHIBIT C

JUDGE ROTENBERG CENTER

A behavioral school for children and adults...

A[redacted] J[redacted]

AUGUST 20, 2009

DOB: [redacted]

A[redacted] is a 15 year old woman with Autism and Mental Retardation. A[redacted] has a long history of severe self-injurious behavior including picking at her gums, slicing her tongue with her finger nails, defecating and smearing, spitting, biting, assaultive behavior, and severe self-injurious behavior. She has been on numerous psychotropic medication in the past including Zyprexa, Seroquel, Klonopin, Topamax, Thorazine, and Risperdal. None of them were effective in controlling her behavior. She has also been in numerous special education and mental health placements. A[redacted] is currently on no medications.

It is clear from A[redacted]'s records and her current stay at the Judge Rotenberg Center that medications and previous treatment programs have not worked for A[redacted]. If A[redacted] were deprived aversive treatment, she runs a severe risk of sustaining a significant injury (or injuring others) during her self-injurious and acting-out behaviors. There are no contraindications to using aversives with A[redacted]. I believe it is the most effective way to control her behavior.

Edward Sassaman, M.D.

EXHIBIT D

JUDGE ROTENBERG CENTER

A behavioral school for children and adults....

D[redacted] P[redacted]

AUGUST 20, 2009

DOB: [redacted]

D[redacted] is an 18 ½ year old man with a Bipolar Disorder, a Mood Disorder, and borderline intelligence. He has a long history of severe behavior problems including assaulting his family and treatment staff, choking staff and destroying property. He has been in numerous special education and mental health placements prior to arriving at the Judge Rotenberg Center. None of those placements was successful in controlling his behavior. Additionally, he has been on psychotropic medications in the past including Depakote and Seroquel. These, too, have not successfully controlled his behavior. He currently is on no medications.

Upon reviewing D[redacted]' records it is clear that neither previous behavior treatment programs nor psychotropic medications have successfully controlled his severe behaviors. If D[redacted] were to be deprived of aversive treatment, he runs a severe risk of serious injury or injuring others as part of his acting out behaviors. There are no contraindications to using aversives with D[redacted]. I believe it is the most effective way to control his behavior.

Edward Sassaman. M.D.

[illegible]

EXHIBIT E

JUDGE ROTENBERG CENTER

A behavioral school for children and adults....

J[redacted] R[redacted]

During the past year, J[redacted] has been restrained several times because of acting out and self injurious behavior. He's been examined after restraint and no significant problems have been found. He has had some minor issues during restraint where he has had a few minor contusions or bruises. He's had some sore muscles. There is one episode where there was a question of an Asthma attack during restraint, but on evaluation, it was obvious that Asthma was not a problem. He's been on numerous medications in the past including Depakote, Lithium, and Seroquel to control behavior. None of these has worked significantly. He is currently on Depakote for behavior.

If J[redacted] is not allowed to participate in the aversive program at he school; it is my opinion that severe behaviors will not get under control, because they have not been brought under control through medication current program. This does place him at risk for having some major injury in the future related to his behavior. There are absolutely no contraindications to using aversive therapy with J[redacted].

Edward Sassaman M.D.

EXHIBIT F

JUDGE ROTENBERG CENTER

A behavioral school for children and adults....

S[redacted] T[redacted]

S[redacted] is a 15 ½ year old man with Mental Retardation and Autism. He has a long history of mediation use in the past. He's been on Zyprexa, Risperdal, Thorazine, Ativan, and Ambien. He came into the school on Zyprexa 15 mg. B.I.D. and 10 mg. at night. Since admission to the JRC, S[redacted] has pulled out one tooth that is a behavior that he has exhibited in the past. He has also had a significant amount self injurious behavior related to scratching his skin and picking at his nails. He also scratches and picks at his toes. He's had at least two documented paronychias associated with self injurious behavior. On exam today, his exam is quite benign except that he does have scratch marks on his arms and signs of picking around his fingers. The remainder of his exam is non-contributory.

SUMMARY

S[redacted] is a 15 ½ year old man with Mental Retardation, Autism, and Significant Self Injurious Behavior. S[redacted] has been on numerous medications in the past to control his behavior, none of which have worked significantly well. His behavior at the JRC continues to be problematic. He still has engaged in some self injurious behavior. He is being treated aggressively with skin preparations. There is no question that he is an excellent candidate for GED and there no contraindications to its use.

Edward Sassaman, IV

Ed Sassaman M.D.

EXHIBIT G

JUDGE ROTENBERG CENTER

A behavioral school for children and adults...

G[redacted] T[redacted]

G[redacted] is a 15 ½ year old man with Mental Retardation and Autism. He has a long history of severe self injurious behavior prior to coming to the JRC. He's been on numerous medications in the past including Klonopin, Clonidine, and Abilify. None of these had any significant success. Over the past six months at the JRC, he's had numerous episodes of severe self injurious behavior with head banging. He has a significant hematoma on the back of his head from which the blood appears to have been reabsorbed, and he is left with redundant skin and underlying scar tissue. He's had episode of bleeding from picking and infections and infections from picking at his nails. He's also picked the side of his face, and on numerous times has scratched himself on his face and neck. He slammed his wrist inside of his desk causing the skin to break down and required antibiotic dressings for that. He's bruised his right eyelid during aggression and restraint and has had several other episode of head banging and self injurious behavior. His exam today is relatively benign. It does show numerous scratches from self injurious behavior and shows the redundant skin in an area on his right occipital area. It's approximately 4 x 5 cm. It's not hard or swollen, but does represent hematomas from which the blood has been reabsorbed. The remainder of his exam is unremarkable.

SUMMARY

G[redacted] is a 15½ year old young man with Autism, Mental Retardation, and Severe Behavior Problems. In evaluating G[redacted]'s records, it is obvious that medication has not worked for him, nor has behavior treatment programs up to date. If left untreated, G[redacted] stands a significant risk of severely injuring himself during his head butting and certainly injuring other students. There are no contraindications to using

aversives for G[redacted] and I think it would be the most successful way to bring his extreme behavior under control.

Edward Sassaman M.D.